FlexSystem Dependent Care Contract

Complete this form to use as substantiation of Dependent Care expenses and submit a copy with each Request for Reimbursement Form. A contract must be completed for each new Plan Year.

PARTICIPANT INFORMATION

Participant's Name: _____

Participant 12-Digit TASC ID (if known) _____

DEPENDENT INFORMATION

Dependent's Name: _____ Age _____

Dependent's Name: _____ Age _____

Dependent's Name: _____ Age _____

PROVIDER CERTIFICATION & INFORMATION

Provider's Name: _____ Tax ID: _____

Provider's Address: _____

I certify the total cost of qualified adult/child care services below have been provided during the period indicated for the dependents on this form.

The total cost for qualified services is $_____ per week/month/other: _____
(circle one)

Service period began ____/_____/____ and continues through _____/____/____.

Provider's Signature: _____ Date: _____/____/____

PARTICIPANT CERTIFICATION

I understand that reimbursements will be limited to my annual salary reduction and are only available for the amount that has been withheld at the time a reimbursement is made for services that have already been incurred.

I understand and agree that I am obligated to inform TASC in writing if the amount charged for the dependent care services change, the service is terminated, or if there is any reason the expenses are not incurred. Failure to notify TASC will jeopardize the tax-free nature of my reimbursements, making it necessary to repay the Plan with after-tax dollars.

Participant's Signature: _____ Date: _____/____/____